SELF SECURE

Self Secure Life

Self Secure Self Managed Superannuation Fund Group Life Insurance

Personal Statement

1 July 2011

Issued by: OnePath Life Limited (OnePath Life)
ABN 33 009 657 176 AFSL 238341
GPO Box 4129, Sydney NSW 2001

Self Secure Life
Level 7
215 Spring Street
Melbourne Vic 3000
Ph 03 8646 4040
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Web www.selfsecure.com.au
Email info@selfsecure.com.au

Important notice

OnePath Life is the insurer in respect of Self Secure SMSF Group Life Insurance. It is important that you have read and understood the current Product Disclosure Statement for this product.

You are requested to complete this form if one of the following applies to you:

- you were unable to satisfactorily complete the health questions on the short form application.
- you wish to apply for a death only or death and TPD sum insured in excess of $750,000.

OnePath Life requires this Personal Statement and other health information to assist us in making a decision on your proposed insurance cover. This Personal Statement is confidential. Please refer to the Privacy Statement in the Product Disclosure Statement.

You may wish to mail, or scan and email this completed form to:

Self Secure Life
Level 7
215 Spring Street
Melbourne Vic 3000
Ph 03 8646 4040
Fax 03 8646 4010
Email info@selfsecure.com.au

OnePath is the insurer in respect of Self Secure SMSF Group Life Insurance. This application form should only be completed after reading the Self Secure SMSF Group Life Insurance Product Disclosure Statement (PDS). The PDS contains a summary of important information about the Self Secure product. The completion of this form serves as an acceptance of the terms and conditions outlined in the PDS.

Your duty of disclosure

You have a duty under the *Insurance Contracts Act 1984* (Cth) to disclose to the insurer every matter that you know or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of insurance and, if so, on what terms.

Your duty of disclosure applies even after your application is completed and until the insurer has assessed and accepted your application for insurance cover, or an increase in cover.

You have the same duty to disclose those matters to the insurer before you change your insurance cover or apply for new cover. Your duty, however, does not require disclosure of a matter that:

- diminishes the risk to be undertaken by the insurer
- is of common knowledge
- the insurer knows, or in the ordinary course of business, ought to know or
- the insurer has waived.

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within three years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

Issued by OnePath a company of ANZ

1. Personal details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Other

Surname First name(s)

Date of birth DD/MM/YYYY Male ☐ Female ☐

Phone Home Work

Mobile

Email

SMSF Name ....

ABN

May one of our underwriting staff or OnePath authorised service providers contact you by phone if we require more information?.................. ☐ Yes ☐ No

If **yes**, when is the most convenient day(s) and time and on which phone number?

Days Time: From To Phone ☐ (H) ☐ (W) ☐ (M)

1. Are you a permanent resident of Australia, or holder of a visa that allows you to work in Australia? .... ☐ Yes ☐ No

2. Amount and type of cover

1. Provide details below regarding the type and amount of cover you are applying for.

- The minimum amount you can apply for is $50,000.
- The maximum is $1 million.
- You can take out death only cover, or death and TPD cover. You cannot take out TPD cover only.
- The death and TPD sum insured can differ however, the TPD sum insured cannot exceed the death sum insured.

☐ Death only cover Death sum insured $

☐ Death & TPD cover Death sum insured $

TPD sum insured $

2. Have you ever had an application for insurance on your life declined, deferred, accepted with a higher than normal premium or issued with restrictions or exclusions? .... ☐ Yes ☐ No

If **yes,** please provide name of company, alteration, date and reason (if known).

3. Have you ever made a claim for or received sickness, accident or disability benefits, Veterans Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation? .... ☐ Yes ☐ No

If **yes,** please provide details i.e. when, amount, period paid, type of disability suffered, date claim finalised etc.

3. Occupation details

Please indicate your occupation. This will help to determine the premium rates applicable to your cover.

☐ White collar The duties of your occupation are limited to professional, administrative, clerical, secretarial or similar sedentary tasks, which do not involve manual work and are undertaken entirely (or at least 80%) within an office environment.

☐ Non-White collar Anyone who doesn't meet the definition of white collar. This includes those not working and/or engaged in home duties.

4. Pastimes

Have you any intention of engaging in:

1. motorcycle/motor racing other than as a means of transportation to and from work?.................. ☐ Yes ☐ No

2. any hazardous activities or sports, e.g. motor or water sports (such as canoeing), football, parachuting, recreations involving heights, underwater sports, caving, body contact sports, gliding, hang gliding etc? .... ☐ Yes ☐ No

3. aviation/flying, other than as a fare-paying passenger? .... ☐ Yes ☐ No

If you answered **yes** to any of questions 1, 2 or 3 above, please continue completing this section below for the relevant activity.

Motorcycle/motor racing

Vehicle type | Races p.a.

Engine size | Max. speed (km/h)

Class | ☐ Recreational ☐ Amateur ☐ Professional

Scuba/skin diving

Average depth (m) | Maximum depth (m)

Dives per annum | Do you use explosives?

Do you dive in caves or potholes? ☐ Yes ☐ No

If **yes,** give details.

Football/Soccer/Aussie Rules, etc.

Code played and grade

Games p.a. | ☐ Recreational ☐ Amateur ☐ Professional

Do you receive any income participating in Football/Soccer/Aussie Rules etc.?

If **yes,** provide amount and details.

Other sports or pastimes

a. Please provide details and frequency of any other hazardous activities or sports you participate in (e.g. boxing, competitive riding, mountain climbing, body contact sports, caving, etc.).

If **yes,** provide frequency and details.

b. On what basis do you partake in this activity? ☐ Recreational ☐ Amateur ☐ Professional

Aviation/flying

Do you hold a Civil Aviation Safety Authority (CASA) licence? ☐ Yes ☐ No

If **yes,** state type and period held.

Do you intend to change the scope of your present licence? ☐ Yes ☐ No

Have you ever had an accident or been charged with violating CASA regulations? ☐ Yes ☐ No

Do you always use authorised landing areas? ☐ Yes ☐ No

Please complete the table below.

No. of hours flown	**Past 12 months**		**Future annual average**	
	Crew	Passenger	Crew	Passenger
Commercial airline				
Charter				
Private				
Aero club/flying school				
Agriculture				
Helicopter				
Ultralight aircraft				

Do you intend to engage in any form of aviation other than the above categories (e.g. ballooning, aerobatics, parachuting, paragliding)? ☐ Yes ☐ No

If **yes**, please provide frequency and details.

5. Personal statement

1. What is your current height and weight? .... Height (cm) ☐☐☐ Weight (kg) ☐☐☐

2. Has your weight varied by more than 10 kg during the last 12 months? .... ☐ Yes ☐ No

If **yes**, please provide details.

3. During the last 12 months have you smoked tobacco or any other substance? .... ☐ Yes ☐ No

If **yes**, please state **type** and **quantity** per day.

4. During the last three months, have you used nicotine replacement treatment? .... ☐ Yes ☐ No

If **yes**, please state **type** used and **duration** of use.

5. Non-smokers – have you ever smoked regularly in the past? .... ☐ Yes ☐ No

If **yes**, please state **type**, **quantity** per day and date ceased.

6. Do you consume alcohol? .... ☐ Yes ☐ No

If **yes,** please state **type** and **quantity** per day (the word 'social' is not sufficient).

7. Have you ever been advised to stop smoking or drinking alcohol on medical grounds? .... ☐ Yes ☐ No

If **yes**, please provide full details.

8. Has the virus which causes AIDS (the Human Immunodeficiency Virus) ever infected you or are you carrying antibodies to that virus? .... ☐ Yes ☐ No

9. Have you **ever** engaged in sexual activity with, or worked as, a prostitute; or engaged in anal sexual activity? .... ☐ Yes ☐ No

If **yes,** a confidential questionnaire will be sent to you to complete and return to OnePath's underwriting department.

If you are required to a have a full medical examination, go to Section 8 on page 7.

6. Family history

To be completed for your blood relatives only (if adopted and family history unknown, please state so).

1. Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic kidney disease, Alzheimer's disease, dementia or any other hereditary or familial disorder? .... ☐ Yes ☐ No

2. Have any of your parents, brothers or sisters (alive or deceased) prior to age 60 been diagnosed with diabetes, heart disease, mental illness, haemophilia, haemochromatosis, high blood pressure, high cholesterol, breast cancer, cervical cancer, bowel cancer or any other cancer (please specify type), stroke or kidney disease? .... ☐ Yes ☐ No

If you answered **yes** to either question 1 or 2, please complete the following table.

Relation	Condition/Disorder	Age diagnosed

7. Medical history

To the best of your knowledge, have you ever had any of the following:

Please tick the appropriate box and circle the specific conditions that are applicable.

1. **Asthma?** ☐ Yes ☐ No
2. **High blood pressure?** ☐ Yes ☐ No
3. **High cholesterol?** ☐ Yes ☐ No
4. **Diabetes?** ☐ Yes ☐ No
5. **Stress, anxiety, depression or any other mental health condition?** ☐ Yes ☐ No
6. **Back or neck pain, sciatica or any disorder of the spine or neck?** ☐ Yes ☐ No
7. **Arthritis, shoulder or knee pain or any other disorder of the joints?** ☐ Yes ☐ No
8. **Cyst, mole or skin lesion?** ☐ Yes ☐ No

If you answered **yes** to any of the conditions in bold above, please complete the relevant questionnaire on pages 9 to 17.

9. Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition? ☐ Yes ☐ No
10. Heart condition, murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? ☐ Yes ☐ No
11. Thyroid or glandular trouble? ☐ Yes ☐ No
12. Ulcers, bowel trouble or recurring indigestion? ☐ Yes ☐ No
13. Epilepsy, fits or dizziness of any kind or persistent headaches? ☐ Yes ☐ No
14. Alzheimer's disease or dementia? ☐ Yes ☐ No
15. Kidney, liver or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis? ☐ Yes ☐ No
16. Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs? ☐ Yes ☐ No
17. Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)? ☐ Yes ☐ No
18. Cancer, tumour, growths of any kind or breast lumps (even if you have not seen a doctor)? ☐ Yes ☐ No
19. Varicose veins, hernia or skin trouble? ☐ Yes ☐ No
20. Any abnormality affecting eyesight, hearing or speech? ☐ Yes ☐ No
21. Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis)? ☐ Yes ☐ No
22. Anaemia, haemophilia or any other disease of the blood? ☐ Yes ☐ No
23. Bowel, liver or gall bladder disease or hepatitis? ☐ Yes ☐ No
24. Coughing of blood or passing of blood from the bowel or in the urine? ☐ Yes ☐ No
25. Any sexually transmittable disease including but not limited to AIDS or its positive antibodies, gonorrhoea or syphilis? ☐ Yes ☐ No
26. Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason? ☐ Yes ☐ No
27. Due to injury or illness have you ever been off work for more than seven consecutive days **(if not already mentioned)**? ☐ Yes ☐ No
28. Do you now have any symptoms of ill health or disability? ☐ Yes ☐ No
29. Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation in the future? ☐ Yes ☐ No
30. Do you take, or have you **ever** taken drugs or any medications on a regular or ongoing basis? ☐ Yes ☐ No
31. Have you **ever** used or injected any drugs not prescribed for you by a medical attendant? ☐ Yes ☐ No
32. Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? ☐ Yes ☐ No
33. **Females only**

a. Have you ever had any complications with pregnancy or childbirth? ☐ Yes ☐ No

b. Are you now pregnant? If **yes**, please advise due date DD/MM/YYYY ☐ Yes ☐ No

c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? ☐ Yes ☐ No

d. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium? ☐ Yes ☐ No

If you answered yes to any questions from 9–33, please complete the following table. If there is not enough space here, please provide details on page 18.

Question no.

Illness, injury or tests

Main symptoms/cause

Date commenced DD/MM/YYYY

Time off work

Has the condition occurred before? Yes No

Date From DD/MM/YYYY to DD/MM/YYYY

How long have you had off work?

Have you fully recovered? Yes No

If yes, give date DD/MM/YYYY

Degree of recovery (%)

Full details of treatment

Date of last symptom DD/MM/YYYY

Further treatment recommended Yes No

If yes, please give details

Full name and address of doctor or hospital consulted

Does your usual doctor have details of this condition? Yes No

Other information

Question no.

Illness, injury or tests

Main symptoms/cause

Date commenced DD/MM/YYYY

Time off work

Has the condition occurred before? Yes No

Date From DD/MM/YYYY to DD/MM/YYYY

How long have you had off work?

Have you fully recovered? Yes No

If yes, give date DD/MM/YYYY

Degree of recovery (%)

Full details of treatment

Date of last symptom DD/MM/YYYY

Further treatment recommended Yes No

If yes, please give details

Full name and address of doctor or hospital consulted

Does your usual doctor have details of this condition? Yes No

Other information

Question no.

Illness, injury or tests

Main symptoms/cause

Date commenced DD/MM/YYYY

Time off work

Has the condition occurred before? Yes No

Date From DD/MM/YYYY to DD/MM/YYYY

How long have you had off work?

Have you fully recovered? Yes No

If yes, give date DD/MM/YYYY

Degree of recovery (%)

Full details of treatment

Date of last symptom DD/MM/YYYY

Further treatment recommended Yes No

If yes, please give details

Full name and address of doctor or hospital consulted

Does your usual doctor have details of this condition? Yes No

Other information

Question no.

Illness, injury or tests

Main symptoms/cause

Date commenced DD/MM/YYYY

Time off work

Has the condition occurred before? Yes No

Date From DD/MM/YYYY to DD/MM/YYYY

How long have you had off work?

Have you fully recovered? Yes No

If yes, give date DD/MM/YYYY

Degree of recovery (%)

Full details of treatment

Date of last symptom DD/MM/YYYY

Further treatment recommended Yes No

If yes, please give details

Full name and address of doctor or hospital consulted

Does your usual doctor have details of this condition? Yes No

Other information

8. Usual doctor or medical centre details

1. Full name and address of usual doctor/medical centre.

Doctor/Medical centre

Phone Fax

No. and street

Suburb/Town State Postcode

How many years have you been attending this doctor/medical centre? .... years months

2. Have you had any consultations with your usual doctor or any other doctor (other than for colds or the flu) in the last three years not already mentioned? .... Yes No

If **yes**, please provide details.

Name, address and phone number of doctor/medical centre	Date last consulted	Reason for check-up or consultation	Outcome including degree of recovery, medication, treatment, etc.
	DD/MM/YYYY		
	DD/MM/YYYY		
	DD/MM/YYYY		
	DD/MM/YYYY		

9. Declaration by the life insured or applicant

- I have read and understood the questions in this Personal Statement.
- I declare that the answers to the questions in this Personal Statement signed by me and given to OnePath Life and/or the Medical Examiner are true and correct.
- I authorise the collection, use and disclosure of my personal information for the purposes of administration and maintenance of this policy, as outlined in the Privacy Statement. I understand that OnePath Life will not be able to process a claim or administer this policy without this consent.
- I accept that where my employer (or former employer) or the Trustee of my superannuation fund has appointed a financial adviser or other intermediary to arrange and/or administer the Group Risk policy on their behalf, my personal information will be provided to the financial adviser/intermediary in order to undertake the management and administration of the policy.
- I declare that I have been clearly informed in writing of the general nature and effect of the duty of disclosure.
- I authorise any medical practitioner, other professional or any person named in this Personal Statement to verify any aspect of it, and disclose any information that they may possess about me to OnePath Life in relation to this insurance.
- I acknowledge that where I am making an application for insurance cover (or an increase in insurance cover), and where such application is made on a voluntary basis (other than as a direct result of the formula for cover which applies to the group risk policy or policies for which an application for cover is being made on the basis of this Personal Statement), that I have received, read and understood a copy of the Group Risk Product Disclosure Statement(s) (PDS) for the type(s) of cover for which I am applying.

Signature of life insured ✗ Date DD/MM/YYYY

10. Authorisations

Doctor's authorisation

To be completed and signed by the life insured.

Please sign authorisation

To doctor

I hereby authorise you to release details of my personal medical history to OnePath Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by OnePath Life. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of life insured

Date of birth DD/MM/YYYY

Signature of life insured

✗

Date DD/MM/YYYY

Address of life insured

State Postcode

Doctor's authorisation

To be completed and signed by the life insured.

Please sign authorisation

To doctor

I hereby authorise you to release details of my personal medical history to OnePath Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by OnePath Life. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of life insured

Date of birth DD/MM/YYYY

Signature of life insured

✗

Date DD/MM/YYYY

Address of life insured

State Postcode

11. Privacy Statement

In this section 'we', 'us' and 'our' refers to OnePath Life and other members of the ANZ Group. We are committed to ensuring the confidentiality, security and privacy of your personal information. 'You' and 'your' refers to policy owners and life insureds.

We collect your personal information to provide you with the products and services you request. Without your personal information, we may not be able to process your application or provide you with the products or services you require.

In order to manage and administer the products and services requested by you, we may need to disclose your personal information to certain third parties, including:

- other members within the ANZ Group, to the extent necessary to service our relationship with you and carry on business as a group
- organisations performing administration or compliance functions in relation to the products and services
- organisations maintaining our information technology systems
- authorised financial institutions
- organisations providing services such as mailing, printing or data verification
- a person who acts on your behalf (such as your financial adviser or your agent)
- the policy owner (where you are a life insured who is not the policy owner).

For life risk products we collect health information with your consent. Your health information will only be disclosed to service providers, reinsurers or organisations providing medical or other services for the purpose of underwriting, assessing the application or assessing any claim.

We may also disclose your personal information in circumstances where we are required to do so by law.

We may send you information about our financial products and services from time to time. You may elect not to receive such information at any time by contacting Customer Services on 133 667.

You may access the personal information OnePath holds about you, subject to permitted exceptions and subject to OnePath still holding that information, by contacting OnePath at:

Privacy Officer – OnePath
GPO Box 75
Sydney NSW 2001
Phone 02 9234 8111
Fax 02 9234 8095
Email privacy@onepath.com.au

If any of your personal information is incorrect or has changed, please let OnePath know by contacting Customer Services.

More information can be found in OnePath's Privacy Policy which can be obtained from its website at onepath.com.au

12. Supplementary questionnaires

Asthma questionnaire

Only complete this questionnaire if you answered **yes** to question 1 in Section 7.

1. When did you have your first episode of asthma? .... Date DD/MM/YYYY

2. When was your most recent episode of asthma? .... Date DD/MM/YYYY

3. Approximately how many episodes have occurred in the last 12 months? ....

4. Have you had any time off work due to this condition? .... ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

5. Are the symptoms/attacks typically precipitated by anything in particular (e.g. seasonal, exercise induced, a cold or bronchitis)? .... ☐ Yes ☐ No

If **yes**, please provide details.

6. Have you sought medical treatment or advice for asthma? .... ☐ Yes ☐ No

If **yes**, please provide details.

Name of doctor/health professional

Address

Suburb/Town State Postcode

Date of last consultation DD/MM/YYYY

7. How has your doctor described your asthma? .... ☐ Mild ☐ Moderate ☐ Severe

8. Have you ever used any medication, including steroids? .... ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable)	Reason for cessation
	DD/MM/YYYY			DD/MM/YYYY	
	DD/MM/YYYY			DD/MM/YYYY	
	DD/MM/YYYY			DD/MM/YYYY	
	DD/MM/YYYY			DD/MM/YYYY	

9. Have you ever been hospitalised due to asthma? .... ☐ Yes ☐ No

If **yes**, please provide details.

Date from DD/MM/YYYY Date to DD/MM/YYYY

Name and address of hospital.

10. Have you ever had lung function tests performed? .... ☐ Yes ☐ No

If **yes**, please provide details.

Date	Test results
DD/MM/YYYY	
DD/MM/YYYY	
DD/MM/YYYY	

Blood pressure questionnaire

Only complete this questionnaire if you answered **yes** to question 2 in Section 7.

1. When was your high blood pressure first diagnosed? .... Date DD/MM/YYYY

2. What was your blood pressure reading at that time? .... Systolic ☐ Diastolic ☐

3. Have you ever been treated by medication? .... ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable)	Reason for cessation
	DD/MM/YYYY			DD/MM/YYYY	
	DD/MM/YYYY			DD/MM/YYYY	
	DD/MM/YYYY			DD/MM/YYYY	
	DD/MM/YYYY			DD/MM/YYYY	

4. Did you undergo any tests or investigations? .... ☐ Yes ☐ No

If **yes**, please provide details.

Tests performed	Date	Results
	DD/MM/YYYY	
	DD/MM/YYYY	

5. Is the treating doctor different to your usual doctor? .... ☐ Yes ☐ No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation DD/MM/YYYY

6. What was the date of your last blood pressure check? .... DD/MM/YYYY

7. What was your blood pressure reading at that time? .... Systolic ☐ Diastolic ☐

8. How has your doctor described your blood pressure control? .... ☐ Excellent ☐ Good ☐ Poor ☐ Other

If **other**, please provide details.

9. What is the date of your next blood pressure check-up? .... Date DD/MM/YYYY

Cholesterol questionnaire

Only complete this questionnaire if you answered **yes** to question 3 in Section 7.

1. When was your high cholesterol first diagnosed? .... Date DD/MM/YYYY

2. What were your cholesterol readings at that time? .... Cholesterol ☐ Triglycerides ☐ HDL Cholesterol ☐ LDL Cholesterol ☐

3. Did you undergo any tests or investigations? .... ☐ Yes ☐ No

If **yes**, please provide details.

Tests performed	Date	Results
	DD/MM/YYYY	
	DD/MM/YYYY	

4a. Have you ever used any medication? .... ☐ Yes ☐ No

If **yes**, please provide details.

Type	Date commenced	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable)	Reason for cessation
	DD/MM/YYYY			DD/MM/YYYY	
	DD/MM/YYYY			DD/MM/YYYY	
	DD/MM/YYYY			DD/MM/YYYY	
	DD/MM/YYYY			DD/MM/YYYY	

4b. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)? .... ☐ Yes ☐ No

If **yes,** please provide date of when treatment changed and the reason(s) for change.

5. Is the treating doctor different to your usual doctor? .... ☐ Yes ☐ No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation DD/MM/YYYY

6. What was the date of your last cholesterol check? .... Date DD/MM/YYYY

7. What were your cholesterol readings at that time? .... Cholesterol ☐ Triglycerides ☐ HDL Cholesterol ☐ LDL Cholesterol ☐

8. How has your doctor described your cholesterol control? .... ☐ Excellent ☐ Good ☐ Poor ☐ Other

If **other,** please provide details.

9. What is the date of your next cholesterol check-up? .... Date DD/MM/YYYY

Diabetes questionnaire

Only complete this questionnaire if you answered **yes** to question 4 in Section 7.

1. When was your diabetes first diagnosed? Date DD/MM/YYYY

2. How is your diabetes controlled?

☐ Insulin – go to question 3

☐ Diet only – go to question 4

☐ Oral – list medications below and then go to question 4

3. How many times a day do you administer insulin? ☐ I'm on an insulin pump ☐ One or two times daily ☐ Three or more times daily

4. How often do you monitor your sugar levels? ☐ One or two times daily ☐ Three or more times daily ☐ Other

If **other**, please provide details.

5. Have you ever had insulin reactions, diabetic coma, heart, kidney, peripheral vascular disease or eye problems (not already mentioned in the Personal Statement), or protein in the urine? ☐ Yes ☐ No

If **yes**, please provide details.

Condition	Date	Treatment
	DD/MM/YYYY	
	DD/MM/YYYY	

6. Have you had a glycosylated haemoglobin (HbA1c) test in the last six months? ☐ Yes ☐ No

If **yes**, please provide details.

Date	Test results
DD/MM/YYYY	
DD/MM/YYYY	

Is this result consistent with others taken over the last 12 months? ☐ Yes ☐ No

If **no**, please provide details.

Date	Test results
DD/MM/YYYY	
DD/MM/YYYY	

7. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation DD/MM/YYYY

Mental health questionnaire

Only complete this questionnaire if you answered **yes** to question 5 in section 7.

1. Please tick the conditions you have had (or currently have), or received treatment for:

☐ Anxiety including generalised anxiety, panic or phobia disorder
☐ Eating disorder including anorexia nervosa or bulimia
☐ Depression including major depression or dysthymia
☐ Manic depressive illness or bi-polar disorder
☐ Alcohol or other substance abuse or addiction
☐ Post traumatic stress
☐ Schizophrenia or any other psychotic disorder
☐ Stress, sleeplessness or chronic tiredness
☐ Other

If **other**, please describe.

2. Please complete the table below for all described conditions.

Condition	Describe your symptoms	Date diagnosed	Date condition ceased (if applicable)
		DD/MM/YYYY	DD/MM/YYYY
		DD/MM/YYYY	DD/MM/YYYY
		DD/MM/YYYY	DD/MM/YYYY
		DD/MM/YYYY	DD/MM/YYYY

3. Have you ever had any recurrence of the symptoms? ☐ Yes ☐ No

If **yes**, please provide details including dates.

4. Are you currently symptom free? ☐ Yes ☐ No

If **yes**, please provide date(s) of last symptoms.

5. Have you ever attempted suicide or self harm? ☐ Yes ☐ No

If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital.

6. Are you aware of the cause or reason for your condition(s)? ☐ Yes ☐ No

If **yes**, please provide details.

7. Have you ever had any time off work due to your condition(s)? ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

8. Are you currently or have you ever been on treatment, including medication? ☐ Yes ☐ No

If **yes**, please provide details.

Treatment (e.g. tranquillisers, sedatives, ECT, counselling, etc.)	Date commenced	Date ceased (if applicable)	Reason ceased
	DD/MM/YYYY	DD/MM/YYYY	
	DD/MM/YYYY	DD/MM/YYYY	

9. Do you feel that your condition(s) has had any impact on your ability to perform your job at work or on your social life? .... ☐ Yes ☐ No

If **yes**, please provide details.

10. Have you been referred for consultation with a psychiatrist or psychologist? .... ☐ Yes ☐ No

If **yes**, please provide details.

Name of consultant

Address

Suburb/Town State Postcode

Date of last consultation DD/MM/YYYY

11. Have you been admitted to hospital or any other care facility? .... ☐ Yes ☐ No

If **yes**, please provide details.

Name of institution

Address

Suburb/Town State Postcode

Date of last consultation DD/MM/YYYY Doctor(s) consulted

12. Does your usual doctor, as indicated in section 8, have details of this condition(s)? .... ☐ Yes ☐ No

Back/Neck questionnaire

Only complete this questionnaire if you answered **yes** to question 6 in Section 7.

1. When did your back/neck condition first occur? .... Date DD/MM/YYYY

2. Which area(s) of your back/neck was affected (e.g. middle back)?

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including the symptoms and doctor's diagnosis if known (e.g. sciatica, prolapsed disc, whiplash etc.):

5. Was an X-ray, CT scan or any other type of investigation performed? .... ☐ Yes ☐ No

If **yes**, please provide details.

Tests	Date of tests	Results
	DD/MM/YYYY	
	DD/MM/YYYY	

6. Have you had recurrent or multiple episodes of the back/neck condition? .... ☐ Yes ☐ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

7. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation)
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	

8. Have you had any time off work due to this condition? .... ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

9. Are your work duties or activities limited/affected by the condition? .... ☐ Yes ☐ No

If **yes**, please provide details.

10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind? .... ☐ Yes ☐ No

If **yes**, please provide details.

11. Overall do you feel that your back/neck condition is: .... ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? .... Date DD/MM/YYYY

Arthritis/Joint questionnaire

Only complete this questionnaire if you answered **yes** to question 7 in Section 7.

1. Which joint is/was affected (please tick relevant box/es)? If more than one box is ticked, please copy this questionnaire and complete for each condition.

	Left	**Right**		**Left**	**Right**
Ankle	☐	☐	Wrist	☐	☐
Elbow	☐	☐	Hip	☐	☐
Shoulder	☐	☐	Other	☐	☐
Knee	☐	☐	If **other**, state which joint		

2. When did this condition first occur? .... Date DD/MM/YYYY

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including symptoms and doctor's diagnosis if known.

5. Have you had recurrent or multiple episodes of the condition? .... ☐ Yes ☐ No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

6. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted	Treatment prescribed (e.g. steroids, anti-inflammatory drugs, surgery, acupuncture)
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	

7. Have you had any time off work due to this condition? .... ☐ Yes ☐ No

If **yes**, please provide the dates and duration.

8. Do you have any residual pain, limitation of movement or restriction of any kind? .... ☐ Yes ☐ No

If **yes**, please provide details.

9. Are your work duties or activities limited/affected by the condition? .... ☐ Yes ☐ No

If **yes**, please provide details.

10. Are you still undergoing treatment? .... ☐ Yes ☐ No

If **yes**, please provide details.

11. Overall do you feel that your condition is: .... ☐ Resolved ☐ Improving ☐ Stable ☐ Deteriorating

12. What was the date of your last symptoms? .... Date DD/MM/YYYY

Cyst/Mole/Skin lesion questionnaire

Only complete this questionnaire if you answered **yes** to question 8 in Section 7.

1. Please provide details in the table below.

Site (e.g. back, left leg)	Date diagnosed	Type (e.g. basal cell carcinoma, melanoma, cyst, mole)	Pathology results (e.g. malignant, benign, unknown)
	DD/MM/YYYY		
	DD/MM/YYYY		
	DD/MM/YYYY		

2. Was the cyst/mole/skin lesion(s) removed? ☐ Yes ☐ No

If **yes**, please provide details for each ... Date of removal DD/MM/YYYY

By what method (e.g. surgically, frozen or burnt off)?

If **no**, please provide details including date set for removal, if applicable.

3. Have you been or are you required to attend any further treatment or regular follow up since the original removal? ☐ Yes ☐ No

If **yes**, please provide details and advise how often follow up is required.

4. Have you had any other tests, investigations or treatments not mentioned above? ☐ Yes ☐ No

If **yes**, please provide details.

Tests/Treatments/Investigations	Date	Results
	DD/MM/YYYY	
	DD/MM/YYYY	
	DD/MM/YYYY	

5. Is the treating doctor different to your usual doctor? ☐ Yes ☐ No

If **yes**, please provide details.

Name

Address

Suburb/Town State Postcode

Date of last consultation DD/MM/YYYY

Additional information/comments

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